MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, January 17, 2002
8:33 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
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ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA item:
What's next for Medicare+Choice
Scott Harrison, Ariel Winter, Susanne Seagrave

MR. HACKBARTH: Good morning. Welcome. First on our agenda for today is what's next for Medicare+Choice. Scott, are you leading?

* DR. HARRISON: I guess so. Today we plan to briefly review our conversation from last month to make sure staff understands the Commission's decisions. Dan will give an up to the minute update on CMS' risk adjustment work. I will then go over the thrust of the draft chapter that staff have prepared for you. We've also prepared a couple of draft recommendations for your consideration. Finally, Ariel will present a table to help clarify our discussion of the GME carve-out discussion.

The Commission, as it recommended last year, is strongly in favor of moving to a payment system where the Medicare program will be financially neutral between its expected payments on behalf of beneficiaries in the traditional program and enrollees in the Medicare+Choice plans. The payment comparison would be made at the local market level. This policy could be operationalized by setting Medicare+Choice payment rates equal to 100 percent of the expected local area per capita risk adjusted spending under the traditional program.

The Commission also reaffirmed that risk adjustment is a crucial component of a financially neutral payment policy. A payment policy cannot be financially neutral if there's not an adequate risk adjustment system in place. And Dan will now discuss what CMS is doing on that.

DR. ZABINSKI: First of all just a quick overview and some background on what CMS had planned is that it thought to implement a multiple site risk adjustment model that uses all diagnosis from hospital inpatient, hospital outpatient, and physician office encounters and they intended to begin using that in January 2004. But the plans complained about the burden of the plan data collection system. So last May the Secretary suspended collection of full encounter data from ambulatory sites.

In response, CMS is now developing a multiple site system that uses diagnosis from inpatient and ambulatory sites of care but would put less burden on plans to collect and submit the data. CMS yesterday had a public meeting to discuss the status of that effort. No final decision has been made and the meeting covered reducing the data collection burden in models that CMS is considering.

To reduce the data collection burden, CMS first of all is decreasing the number of data elements that plans must submit. The initial data collection required plans to submit information that would have made auditing easier and would have allowed CMS eventual use of encounter data to calibrate the risk adjustment

model.

But many of those variables are not necessary to run a risk adjustment model. The only variables that plans will now have to submit are simply beneficiaries' ID, diagnosis codes, beginning and ending dates for a particular service, type of bill such as inpatient, outpatient, or physician office, and possibly an indicator of the principal inpatient diagnosis.

CMS is further decreasing burden by reducing the number of diagnoses that it will use to risk adjust payments. Consequently, plans only have to submit those diagnoses that will result in higher payments although they may submit as many diagnoses as they want. If a diagnosis does not result in a higher payment they can submit those as well if that's easier for them to submit a whole batch. Also plans will only have to submit data quarterly rather than monthly, and they only have to submit conditions triggering higher payment once each annual reporting period rather than repeatedly like they currently do.

Now the multiple site models that CMS is considering fall into three general categories. First of all, CMS might use one of the multiple site risk adjustment models it had under consideration before data collection was suspended, such as the hierarchical condition category model, but they would use fewer diagnoses than a full model. The number of categories that they would use could be as few as six or as many as 100, but 100 has been determined to include all the categories that are significant in terms of predicting cost.

CMS has to decide how many categories to use and which ones to include in the eventual model. It also has to consider the conflicting issues that, first of all, more conditions would improve predictive power, but then it would also increase data collection burden.

In any event, all diagnosis categories selected for use would be filled with diagnoses from both inpatient and ambulatory encounters, and payment for a condition would be the same whether a diagnosis is inpatient or ambulatory.

A second option CMS is considering is once again using a multiple site model under consideration before data collection was suspended but first of all include only the 100 significant diagnosis categories I mentioned earlier and fill most of those with only diagnosis from inpatient encounters. A few selected additional categories would be also filled with ambulatory diagnosis. In categories that would use both inpatient and ambulatory data -- I'm not certain about this but I believe the idea is that the payment rates would depend upon site of care. The payment rate would differ if it's an inpatient or an ambulatory diagnosis.

Finally, CMS is considering the current PIP DCG model; that is, the inpatient-only model, but would then add some diagnosis categories for some ambulatory diagnoses. Once again, I believe the payment rate would depend on site of care.

Finally, CMS released some important dates I think we should pay attention to. First of all it will announce which diagnosis will trigger higher payments in whatever model they eventually decide to use on March 29, 2002. Plans will begin collecting diagnosis information on July 1st, 2002. CMS will announce which multiple site model it will use on January 15th, 2003, and then they will begin using the model on January 1st, 2004.

DR. HARRISON: Last time we also discussed the carve-out of payments to teaching hospitals for GME cost from the calculation of Medicare+Choice rates. The Commission believed that the carve-out policy provides incentives for plans to contract with teaching hospitals. At the end of our presentation today Ariel will go over a table that shows some examples of what we might expect to happen under a financially neutral payment system with a carve-out.

We also discussed that the use of competitive bidding to set payment rates would introduce cost saving incentives and address some geographic equity issues. However, it would also introduce new equity concerns and cause redistribution of resources such that it would probably be very difficult to generate a political consensus to support it.

Now let's turn to the chapter draft. The first main point is that we want to move to a financially neutral payment system. We've covered why we're unhappy with the current system repeatedly and I don't really think you want to hear me go through that again. We've also expressed strong support for the rapid development of an adequate risk adjustment system over the past few years and we want to stress that again in the chapter.

The last half of the chapter examines competitive bidding and how it might be used within a financially neutral payment system to address some of the remaining issues that we would have after moving to a system that sets rates at 100 percent of fee-for-service.

The three issues we look at are cost reduction, availability of plans, and geographic equity. A system that sets rates at 100 percent of risk adjusted fee-for-service payments is not designed to save money. In fact, unless the savings from risk adjustment were larger than the cost of the average increase in rates needed to reach 100 percent, then the system would result in a little added cost to the Medicare program. Because competitive bidding systems would treat fee-for-service spending as a rate ceiling however, competitive bidding would save money relative to setting rates at 100 percent of fee-for-service.

We also acknowledge that moving to a financially neutral payment system is unlikely to increase the availability into currently low paid areas because those areas would usually end up with lower payment rates under financial neutrality since the floors would be eliminated under such a system. Competitive bidding would not help these areas get plans though because it would only result in lower payment rates. Thus it is unlikely

that plans that would enter areas where they don't already exist.

The last remaining issue is equity. The financially neutral payment system was designed to address equity between beneficiaries in the traditional program and enrollees in Medicare+Choice plans within a local market. It would not address equity across geographic markets. Some see the current system, and a system that paid 100 percent of fee-for-service rates also, as equitable because all beneficiaries across the country can join the program by paying the same Part B premium. Others see it as inequitable because beneficiaries may have access to richer benefit packages depending on where they live. Paying 100 percent of fee-for-service would not change those equity considerations significantly.

Using competitive bidding to set rates would greatly change the equity consideration. First, the entitlement would change from the traditional program to the benefits that are offered under the traditional program without being guaranteed the broad choice of providers that are available in the traditional program. While all beneficiaries across the country would be guaranteed the basic benefit package for a set national premium, beneficiaries would have to pay more to stay in the traditional program in some parts of the country.

Now compared with a system where payments are set at 100 percent of fee-for-service, the only way any beneficiaries would be better off is if the cost savings from competitive bidding were redistributed to all beneficiaries in the form of either lower Part B premiums or an improvement in the basic benefit package. This shows why people who were interested in competitive bidding thought that that couldn't happen without adding benefits at the same time and I think that just shows why.

That concludes the focus of the chapter. Ariel will -- actually we'll do the draft recommendations first.

The Secretary should ensure that an adequate risk adjuster is used to pay Medicare+Choice plans as soon as possible. This adjuster should not impose an undue burden on plans and providers.

This is a slightly stronger statement than we made last year, but it's a requisite for recommendation two.

DR. ROWE: Can we discuss the recommendation?

DR. HARRISON: There's only two of them so you could discuss them at the same time.

MR. HACKBARTH: My thinking, just in the process was, let's get it all out on the table, including the draft recommendations, and then go back and discuss everything that's been put on the table.

DR. HARRISON: Then draft recommendation two is, When adequate risk adjustment is in place, the Congress should set risk adjusted payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending.

So those are the two recommendations. Now we can go over

the carve-out or discuss the recommendations now. Just go to the carve-out?

MR. HACKBARTH: Yes, get it all out and then we'll discuss --

MR. WINTER: This actually illustrates the impact of moving to financially neutral payment rates both with and without the carve-out. So essentially it illustrates the last part of draft recommendation two, which is to set payments at 100 percent of per capita local fee-for-service spending.

We've picked some selected counties to use as examples. The first group of counties are those that received 2 percent updates in 2002, the second group are those that received the floor rates in 2002. The first column shows the current M+C rates. The second column shows local per capita fee-for-service costs in 2002. The third column shows per capita fee-for-service costs less GME and IME spending. This would be the base rate in a financially neutral payment system that removes those GME and IME payments. And the fourth column shows the GME and IME cost as a percent of local fee-for-service costs.

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We find that spending declined between '97 and '99. We don't know actually what spending looks like in Manhattan in years after that but we've just assumed that it follows the national trend.

DR. ROWE: I understand. So then you're recommending -- we can get to the recommendations, but just so I understand, you would be recommending then that the M+C rate in Manhattan be reduced --

MR. WINTER: That's the logical conclusion from --

DR. ROWE: because you're recommending 100 percent of the per capita fee-for-service costs.

MR. WINTER: Right. What the Commission has said at the last meeting where we talked about the GME and IME carve-out is that those payments should be removed from local fee-for-service costs when calculating payment rates. So therefore, that leaves us with a third column as the most likely base rates in the Commission's recommended payment system.

DR. ROWE: Even forgetting the GME carve-out, 795 is higher than 760.

MR. WINTER: That's right.

DR. ROWE: Because we kind of got into this discussion about how can we fix the M+C program, and your recommendation is that we reduce the payment rate.

MR. HACKBARTH: But, Jack, it's easy to imagine a scenario under which if our recommendation were adopted that the M+C rate would not be lower. Our goal is to have the M+C rate equal to 100 percent of underlying fee-for-service costs. If we stay with the current system and they're constrained by the 2 percent increase and fee-for-service costs start going up by more than 2

percent --

DR. ROWE: I'm well aware --

MR. HACKBARTH: -- then you would find that HMOs in Manhattan would benefit from our proposals.

DR. ROWE: I'm very familiar with that problem.

MR. HACKBARTH: So this is a temporary --

DR. ROWE: Okay, I just want to make sure I understand what --

MR. WINTER: This is a snapshot, 2002.

DR. REISCHAUER: But also, if per capita fee-for-service spending in Manhattan had grown, after the two years of decline, at 7 percent, as Jack probably suspects it has, then there would be an increase. This is really your general assumption that Manhattan was like the nation as a whole.

MR. WINTER: That's correct.

DR. REISCHAUER: It may be, but maybe not. But certainly over the long run, Jack, it's not going to come out the way you --

DR. ROWE: I understand. I just want to make sure I understand how we got here. Is this Portland, Maine or Portland, Oregon?

MR. WINTER: It's Portland, Oregon; Multnomah County.

DR. REISCHAUER: On draft recommendation one, I realize that it is sort of a preamble for number two, but it sort of is like, we think the Secretary should follow the policy he's already following, isn't it?

DR. HARRISON: Yes. One danger though of only doing two is that people might forget to do one, say in the legislative proposals that might be coming out. Now the question is, I guess, whether you think everything is on track, and if it is then there's not a problem.

DR. REISCHAUER: Maybe you can put it all in the text as opposed to in a recommendation. But it strikes me as stupid when we --

MR. HACKBARTH: The first clause of recommendation two makes explicit reference to having an adequate risk adjustment as the necessary prior step. So it seems a bit redundant to me, also, to make recommendation one.

DR. ROWE: Can we talk about the adequacy issue? We have a term there, adequate, and I assume that the cognoscenti with respect to risk adjustment must have therefore some proportion of the variance that is described by it that meets that criterion. I mean, what's adequate?

DR. NEWHOUSE: Nobody knows.

MR. HACKBARTH: It would be helpful to me if at least we could better understand how CMS is evaluating the trade-offs. There is at least one obvious trade-off between predictive power and burden on the plans. How are they thinking about that issue?

DR. ZABINSKI: They gave no indication yesterday of how they're thinking about that issue. I know they're concerned.

Their two concerns are, first of all, predictive power, and second of all, data collection burden, and they're trying to balance the two.

DR. ROWE: Did they describe the proportion of the variance, or the predictive power of the different models that --

DR. ZABINSKI: Yes. I think the lowest they had would be about 7.5 percent and the highest I think was 11/5 percent. For example, they include -- like I said earlier, they'll include as few as six diagnoses and as many as 100. If they include only six it's 7.5 percent variation. If they include 100 it will be 11.5 percent.

MR. HACKBARTH: To this point they have not said, we don't feel we can go below X percent and still be adequate.

DR. NEWHOUSE: Scientifically we just don't know. What we know is that if you explained everything that was predictable you'd be somewhere north of probably 25 percent. But we don't know how far short of that you would have to be before you'd have a tolerably good risk adjuster. I mean, you're never going to be perfect, but in the real world you don't have to be perfect. We just don't know how good you have to be, because all our observations are down in the range of you explain 1 percent or so. We know that doesn't work. Beyond that we just don't know how well you'll do.

DR. ROWE: What term should we use in the recommendation? You write papers and do research in this area. What would we use?

DR. NEWHOUSE: I don't have a better one, off the top.

MR. HACKBARTH: Joe, I agree completely with your point but a decision needs to be made, and you can either have an implicit standard of what constitutes adequacy or an explicit standard. So my question was, how are they going to make the decision? Are they just going to mumble, we think this is right, or are they going to say, here's how we think about it?

DR. NEWHOUSE: I think it will presumably be a trial and error process. We'll put something in place and see how much selection is observed. Then if we think that's too much we'll try to do something else, although it's not totally clear where we get anywhere near as big an increment as we're going to get from diagnosis.

DR. REISCHAUER: I think the term adequate means a risk adjuster which makes it inefficient for plans to invest in activities to attract low risk people. So it depends very much on the behavior of plans. Then you can substitute regulation, penalties, whatever for risk adjuster as well.

DR. ROWE: I understand.

DR. ROSS: Can I offer just a clarifying point? CMS has implicitly set an upper bound in terms of what it considers in announcing a suspension of the current system. That reflects a judgment that the data collection costs there were too high in return for the variation in resources that was being explained.

Although as I recall when that suspension was announced it was, we'll look and see if we can come up with something better; i.e., lower cost with similar explanatory power. But that was their judgment that that was too much burden and not enough power.

DR. ROWE: I guess my concern in the real world here is two things. One is that the Medicare+Choice program is not prospering and there is a lot of concern in Congress and elsewhere about trying to do something to bolster it, or save it, and revise it, or strengthen it, turn it around, et cetera. What we're recommending, which is going to 100 percent of the fee-for-service, is likely to have a modest positive effect in that direction. Not dramatic, as you can see from the figures. Modest, but nonetheless positive, with the possible exception with a couple of idiosyncratic places.

But we are tethering that to the implementation of this risk adjuster and we have now been told this morning that that will not be started until January of '04. It seems to me that the perfect might be driving out the good here, and that an additional two years under the current system before the payment rate is adjusted to 100 percent, because we don't want to do that without explaining this additional five or six or 7 percent of the variance -- and I understand the reason for that -- might be too late. It just might be too little, too late.

It's academically understandable how we might want to link those two things, but from a policy point of view I'm not certain that it makes sense. So I think I'd be interested in what commissioners think about it.

DR. REISCHAUER: I was going to say, we don't know, if we had a level playing field, whether Medicare+Choice is a viable entity. In the sense that we have on one side the fee-for-service system which is the mother of all price discounters, and on the other side a method of providing services that has an unattractive aspect to some beneficiaries in that it restricts choice. If you pay them both the same, the plans have to cover marketing profit, higher administrative costs, and provide something to entice beneficiaries to join.

Without the kind of formulation that Scott has put forward where in the areas where these plans are more efficient and provide the same services but in a different framework cheaper, and you charge people more if they want to change in fee-for-service -- without going to something like that you don't know, if we level the playing field, five years from now there will be really very few plans left in America.

DR. ROWE: I accept that, Bob, but I think we don't know. It might strengthen the program. It might not be enough. But what about my concern about the fact that during this interval period of -- perhaps critical period for the future, that perhaps it's not appropriate to delay two years before we level the playing field, just so we could have the advantage of the coincident modest increase in variance explained by the risk

adjustment. That's my --

MR. HACKBARTH: Jack, the reason that we link the two was that there is a lot of research suggesting that currently we're overpaying the plans because of preferential risk selection. If in fact that's the case, going up to 100 percent is not moving you in the proper direction.

So what we've said is, we think financial neutrality requires both steps: accurate risk adjustment and then going to 100 percent. Not paying more if in fact the plans are benefiting from risk selection. So that was the reason for --

DR. ROWE: I understand that and I appreciate that. And for all the reasons that Bob mentioned, even though we may be paying more than Medicare would be spending on those people, it's not enough to entice the plans to enter or to stay. So I think we understand that. I was under the impression that the difference between the characteristics of the M+C beneficiaries and the fee-for-service beneficiaries had narrowed, or was narrowing. You would have the data and I don't, and we can hear about that.

But notwithstanding that, it would seem to me that some incremental approach to try to do something during these two years might, from a policy point of view, be warranted, if one accepts the fact that Congress and the American people appear to want to have this program. That's just where I come out, I guess. But I'd be interested in the data on the difference with respect to the characteristics of the M+C versus fee-for-service bene's at this point, whether it is in fact narrowing or not.

MS. NEWPORT: I think I would have the same issue that Jack does, although I came in in the middle of this conversation. I apologize for that.

The issue in terms of a risk adjustment, imposing it as adequate and imposing it as soon as possible at this point I think it just another level of uncertainty that's imposed on the program. So I think that from the overarching policy standpoint, a risk adjuster is something that's been very, very well imbedded in the thought process around what M+C should be.

But in effort to make Sheila feel maybe younger on some of this stuff --

[Laughter.]

MS. NEWPORT: My recollection unfortunately is back to TEFRA on this, where the whole thought process was not about saving Medicare money. It was providing options, and indeed having health plans participate in Medicare in the same manner they participated in the commercial or under-65 markets, which was prepaid health care.

The value added that may have accrued to the program -- in this case the beneficiaries -- there was this what I'll call a safety net, for lack of a better word, which was a filing system that said that in case the revenue was more to the plans than the actual value of the benefits, the plans were required to add in other benefits. That value and the savings didn't accrue to the

government. It accrued to the beneficiaries.

So the savings in terms of so-called overpayment is not necessarily savings -- and I think the frustration on the policy side has been it hasn't been savings to the government, but it has been savings to the beneficiary. As the argument of savings to the government has overwhelmed the initial thoughts and behind the program, then we get into these rather awkward arguments about adjusting payment so that it's the most value at a different level than it was anticipated being from at the onset of the program.

So I do have problems right now in terms of trying to stabilize a program that had value for many years, and still has perceived value to the beneficiaries, with a precision on payment that seems to then, again, overwhelm the additive value of the drug benefits. Which really does help the beneficiaries in other ways too because they don't have to buy Med supp products to pay for the differential and deductibles and copays they would incur on the fee-for-service side.

So at any rate, I guess hopefully Jack and I are aligned here, but I think that as soon as possible, to me imposes an undue burden on plans. I think that I would comment that way. I am concerned about that, because we will go from hundreds of thousands of data submissions, even with a skinnier dataset that we anticipate on risk adjustment to still millions.

Our experience so far with the data submission on risk adjustment has been very problematical. If you just look at yesterday's notice on the USPCC update, we're having adjustments to the base that seem to occur every year because for some reason HCFA -- the tail on the data, each year they've overestimated what they should pay us. It seems to me that the five-year lookback on some of this data, it's the same experience we had on the fee-for-service side using 1999 data to base our updates on for any of the other sectors.

So I'm very concerned with the wording of this, and that at this point, without knowing what Congress is even going to do this year or what reform will look like, if we even get to that, I find this counterintuitive to say, let's put this in place and then expect that it will stabilize the program.

MR. MULLER: It just strikes me at a macro view we've kind of ground ourselves to a policy halt here, because the plans don't want to offer the benefit because it's just not financially attractive to them anymore. The government doesn't want to, in a sense, keep sponsoring it because it feels it's overpaying. And the beneficiaries don't want it any more because without the added benefits that were available four or five years ago to attract them in, they're not willing to have the kinds of constraints on choice, especially as the insurance market has changed quite a bit.

So I think in some ways that we unfortunately have fallen into a kind of black hole here -- not to create another metaphor

-- but where everybody doesn't want to go forward for a variety of reasons. The way in which the program was financed five, seven years ago by fairly considerable changes in behavior; e.g., constraints on hospitalization, et cetera, are not as feasibly, medically, politically, legally any more. So the way in which essentially the program was financed is not there any more.

So I just think we're in a bad spot in terms of going forward because none of the parties to the transaction, the plans, the payer, or the beneficiaries, want it.

MR. SMITH: Ralph headed in the same direction I wanted to. The difficulty here is we do know that we could pay enough to stabilize the system; at least keep plans in and keep enrollees enrolled. But we have no idea whether that's a good idea or not. Jack is suggesting that we ought to go partway down that road because Congress might go partway down that road.

But it seems to me that we've laid out an argument here that does reflect the black hole that Ralph suggested. That if this plan is going to work, it's got to work in a financially neutral way. That has to be part of what we say is a minimal outcome. Going ahead with 100 percent before there's a risk adjuster in place violates that proposition.

Now it seems to me if we're going to do what Jack suggests we need to back away from what seems to me to be, both from a policy point of view and a principle point of view, a very important starting proposition. There was always some uncertainty about whether this would work. Now that uncertainty is intensified. The only thing we know is that there's some amount of money that we could throw into the system that could make it work. We don't want to do that. That would violate the notion of financial neutrality. So Jack wants to violate the notion of financial neutrality a little bit on the hope that we'll get a little bit of stabilization.

I don't think stabilization is our objective here, and we need to be -- or we certainly haven't said stabilization is our objective. If we're going to head down that road we need to revisit the principles that we've articulated over the last couple years. I'd be very reluctant to do that.

MR. FEEZOR: I guess I would have to take a little exception with Ralph's observations. I have 250,000 retirees in my program; three-quarters of them, up until about two years ago, were in Medicare+Choice programs. I went from five Medicare+Choice vendors to two. I'm not sure how -- and I can tell you at each one of those withdrawals where Medicare supplemental arrangements were substituted for Medicare+Choice I and my board took a lot of heat. So I think at least for those who have been a part of it, who have enjoyed -- probably have enjoyed without paying the full value, I think. Ralph, that's where I think you would be right. If enrollees have to pay maybe full value, however you might calculate that, there's probably a little different mix. But those who have it clearly want it.

I guess the other thing is, I take some agreement with Jack. When I was with the Blues I remember we were still talking about risk selection in the FEHBP program in terms of the high option, low option and could we correct that. The issue of risk adjustment has been around. It's a question of which of 15 methodologies, now down to six, seem to have better predictive powers. It really is, I think, a matter of lack of concentrated will to in fact go ahead and make a prudent choice, decide what risk adjusters you feel like make some sense. You're never going to get to 100 percent. You'll probably never get much above 50 percent in terms of predictive, at least in our lifetimes.

The question is, is it a fundamental tool that can help assist the program in terms of achieving the value for enrollees. I don't know where I come out on that except that I think it's probably time to call the issue. If in fact we believe in financial neutrality and in fact that risk adjustment is in fact a step in the right direction, then I think there needs to be some urgency and intensity brought to that. And dealing with data submissions, in all due respect, none of my vendors -- some of the same individuals -- appreciate the kind of data that I try to get from them to validate the rates that I have to deal with and negotiate. That's always going to be a complaint and it should not stand in the way of in fact designing a system for long term permanence and value.

DR. STOWERS: I don't want to interrupt the flow of this conversation. I just had a question on recommendation two. I know we've talked about the carve-out in other places and yet we say here 100 percent. Are we talking column two or column three as the end recommendation two?

DR. HARRISON: We don't in that recommendation say how we would measure local fee-for-service spending. My presumption is that we're doing column three.

DR. STOWERS: So should we put, less the carve-out on that?

DR. HARRISON: We could if you want to.

DR. REISCHAUER: I'd like to side with Jack and disagree with David. I know that makes you very uncomfortable, Jack, but stick with me.

[Laughter.]

DR. REISCHAUER: There is a very real possibility that Medicare+Choice -- not talking about private fee-for-service plans but plans, you guys -- is on the endangered species list and by the time we get risk adjustment and financial neutrality it's going to be extinct. We have to ask ourselves, is preservation of this type of entity worth something because we think it might play some role in future Medicare policy? If it becomes extinct it's not going to come back. Or it will come back only over a very, very long period of time.

I think what Jack is saying is, why don't we go to 100 percent fee-for-service now. I think you can make a case that that is not necessarily bad policy, even without risk adjustment,

because of our ignorance at this point. There's been huge changes in the enrollment in these plans. Some plans have gone out of existence. We have a different set of incentives by the lock-ins that we have in place, and that will selectively cause disenrollment or different people to enroll. Many plans now are charging premiums for the benefits that they're providing, whereas they didn't before. So this would probably drive the healthiest of people out of these plans. And then there's always the claim that the group is aging.

So I don't really know I don't think, and I don't think anybody knows the extent to which we have favorable risk selection in these plans right now. It's conceivable that there isn't much of that now. We gather our data and five years from now we say, you know, it's funny, they went extinct and there wasn't this.

Now the thing that worries me about going to 100 percent within the risk adjustment in place is that we might never get the risk adjustment. The political forces that we've seen operating over the last few years might be so powerful that that's the end of it in terms of trying to make the adjustment. But I think you can make a pretty good case that moving to 100 percent now with risk adjustment phasing in over the next three or four years is the prudent course, if you think having plans that could be part of a competitive model or could give people choice is an important thing for keeping our options for the future of Medicare as broad as possible.

MR. HACKBARTH: I don't want to see the program go out of existence. Both in my government service and in my private career, it's basically been involved in trying to create managed care delivery systems that can serve both private and public enrollees. So I'm a believer in this.

The biggest reservation, Bob, I have about let's do something temporary to keep it alive is that I think that, yes, there are problems on the public policy side: problems in our risk adjustment, problems with the ceilings and floors that I think are destructive and making life more difficult. But I think part of the difficulty we face right now is attributable to what's happening in the plans themselves and how managed care has evolved, for very understandable reasons. But it's evolved in a way that it's less able to manage care.

The networks are very large, if not all-inclusive in some cases. For a variety of reasons, including political and public relations, tools that could help manage costs have been abandoned. So the difference between what the private plans are offering and what fee-for-service Medicare is offering has diminished. I think that is at least as important in the fiscal difficulties of the plans as anything on the Medicare side of the ledger.

So what gives me pause is paying more money, more than they we would have spent in Medicare, for something that's basically

become Medicare-like. I don't see the public interest in --

DR. REISCHAUER: But what I'm saying is, I don't know if we're paying more than we would pay under Medicare. I think we have a lot of studies based on data from three to 10 years ago, but the world has changed tremendously since then. I'd like to actually hear from the staff on whether that's true. Maybe I'm wrong. Maybe there's some new studies out that -- I mean, you guys had a regression and I didn't know where it came from, 1.016. So maybe that's the latest.

DR. HARRISON: That was without risk adjustment. But we do have risk adjustment now. Right now it's stuck at 10 percent on the PIP DCG. If the only thing you did was to allow that to go higher I'm sure that that would -- it might even -- well, I don't know if it would over-compensate or under-compensate but it would certainly do some risk adjustment that could be considered adequate.

DR. ROWE: But what about the populations now as far as the most recent data that we have, how much difference is there?

DR. ZABINSKI: That data I think is -- I'm trying to remember -- it was fairly aged as well.

MR. HACKBARTH: Joe, can you shed some light on this?

DR. NEWHOUSE: I haven't seen any real recent data. The most recent data I've seen was the distribution HCFA put out when it announced the impact of the PIP DCGs by plan, which you'll recall was where we got the 7 percent hit when fully phased in, but there was still a spread with several plans gaining from risk adjustment.

The point I wanted to make, I come out generally where Bob Reischauer does, but there's an issue about how much we want to be governed by the average or the mean versus the distribution. There was quite a spread in the impact of risk adjustment, and the flip side of that being how much selection as measured by PIP DCGs, across the different plans. Some plans were gaining a lot. As I recall there were some plans that would lose in the teens percents of their reimbursement, while other plans would have gained. Another way of saying that is, some plans are profiting a lot, other plans are actually suffering from adverse selection.

So I'm not sure it's all that persuasive to say that on average, across all plans, there's selection that goes against the government and therefore we shouldn't go to 100 percent. Nor as we look at the impacts in this table by geographic place, it's not clear that those are actually the real impacts, because we don't know what the selection is in each of those places. This is before any selection occurs. And then even within those places, insofar as there's multiple plans, there will be different impacts by plan.

So I think the way we want to think about the going to 100 percent point is some of the plans right kind of in the middle of that distribution would move up to where they would benefit. Other plans are still going to be losers and winners in this.

But it's going to be a quite different picture across all the plans. I'm just impressed with how much of a spread there was across the plans.

While I've got the floor I wanted to say one other thing that doesn't bear immediately on the policy but it does bear on the chapter, which is the chapter -- it didn't come into this discussion, has a proposal or some language about if we go to competitive bidding the government subsidy should be at the lowest bid.

I don't think we should take a position on that issue. I think that's the first rank political question and goes to the division of the burden between beneficiaries and taxpayers. We can have a financially neutral system with the government paying anything so long as the beneficiary is able to collect all or almost all of the difference if the beneficiary chooses a plan that costs less than what the government is paying. I think that's the principle we want to insist on.

DR. HARRISON: We did not intend to say that you would pick the lowest. That was just the easiest example to explain.

DR. NEWHOUSE: That's not how I read the language in the chapter.

MR. HACKBARTH: I agree with what you're saying, it's not written as an endorsement, but an illustration of how it might work. There are other potential models that maybe we would do well to make reference --

DR. NEWHOUSE: We should strive to be explicitly neutral on, or agnostic, about what the government contribution should be, or the level it should be set at. The principle we want to emphasize is that the beneficiary pays or receives the difference in either direction.

MR. HACKBARTH: The benefits in terms of reducing program costs of the model in the paper are greatest, but also it has the greatest risk in terms of selection problems and the like. So again, choice is trade-offs to be made among different public policy goals there and I think we could add to the text some discussion that highlights that.

DR. HARRISON: The only other thing was that I tried to say that if you were to go to some other model the effects would be similar. They may just be different in degree, but they would be similar in kind. That was the other thing that --

DR. NEWHOUSE: I don't even see any reason they would be different in degree. The first order effect is who pays, the beneficiary or the taxpayer?

MR. HACKBARTH: Right. But one of my concerns about the lowest bid model with the Medicare entitlement being redefined, you're entitled to this benefit package from the lowest bidder, is that then the beneficiary becomes the risk bearer in terms of selection issues. If the cost of Medicare is driven up by adverse selection, the beneficiaries remaining in the traditional program have to pay for it in increased premiums, as opposed to

some other models where the government would continue to be the bearer of the risk of adverse selection. That's a critical policy choice I think.

DR. NEWHOUSE: Yes, but it's not clear that Congress needs us to tell them how to make that choice.

MR. HACKBARTH: We ought to be elucidating the choice as opposed to --

DR. ROWE: We've had a lot of discussion of this other issue. I wanted to move to one other issue for the chapter also and put my geriatrician hat on for a minute. I think that it would be helpful to look at this situation not only from the point of view of the government, the program, which has been the lens that we've been discussing about neutrality, et cetera, and whether the government is overpaying or underpaying, or isn't overpaying as much as it might have been, et cetera, but from the point of view of the beneficiary.

A lot of the implicit comparison in the chapter is the traditional fee-for-service program versus Medicare+Choice when we talk about the beneficiary in that one section. I think the relevant comparison is traditional fee-for-service plus Medigap versus Medicare+Choice.

The overwhelming majority of the beneficiaries in the traditional fee-for-service program have a Medigap supplemental program. The premiums are changing there. That situation is fluid. For my mother who's 92 in New Jersey trying to figure out what to do, it's what it's costing her out-of-pocket vis-a-vis choice and these other restrictions for the Medigap policy plus Medicare versus what she can get from Medicare+Choice, and what's happening to the supplemental premiums that Medicare+Choice is charging. You mentioned that, but there are some limitations on what can be charged, et cetera.

I think it would be helpful to add that dimension to the chapter because that's really where the beneficiary is. As Allen pointed out, his beneficiaries migrated from Medicare+Choice to Medicare plus Medigap, and weren't happy with it, and they're probably unhappier now but there's nowhere to go. So that would be something I'd ask you to consider adding some stuff in.

MR. HACKBARTH: I have Alan, Janet, and David, then we need to, I think, start to bring this to a conclusion.

DR. NELSON: I favor the notion of Medicare beneficiaries having choices. As a beneficiary, I'm perfectly willing to go to the Congress and lobby for some policies that would allow that to happen. But I think it's important for the Commission to have some principles and adhere to those principles, and they've been articulated in the past meetings, in favor of moving to the financially neutral payment system and an adequate risk adjustment system. I think it would be a mistake for the Commission to retreat from those under the notion that some fix is necessary in the shorter term.

There will be plenty of other people that can advocate that,

so I support what Dave said earlier.

I also support the recommendations. Getting back to the recommendations, I support them.

MS. NEWPORT: I guess maybe that's my question rather than a comment is -- I don't have a good sense of where we are with this right now, but I appreciate the comments of Bob and Alan as well.

It's not that just -- we recognize that supplying data is a necessary part of being in business. I think the issue right now is at what cost and the timing in terms of the stability of the program. I was rather gratified this past year or so that folks came around to the budget neutrality of paying 100 percent with a proper price fixer, if you will, stabilizer in terms of -- is the money going to the right place and is it of value to beneficiaries ultimately?

So I wanted to be clear that my concern -- what i want to be clear on is the timing of this and the level of uncertainty, so that folks know that that's the issue is, when you're making long term business decisions and every year you have a bit of a surprise in terms of what's going on, what you're going to be paid, what your revenue is going to be. And then you have to impose that surprise on your customers, your beneficiaries. And then you have to deal with the money markets as well in terms of what you're doing. It is a very, very disconcerting period of time.

Notwithstanding the fact that everybody seems to think that lack of choice to beneficiaries once they're in a plan, beneficiaries love the program. We have extraordinarily good response to being in plans as a matter of fact. That's why it grew so rapidly; the benefits were good. I think that that value added was an important notion that we don't want to lose.

So I'm not sure where we've been left with the wording of the recommendation, but I want it understood that being in a Medicare+Choice plan didn't even occur to some beneficiaries as being a restriction on their choice. It actually -- they were very happy with it. I think that's what we'd like to go kind of what I call back to the future a little bit is, let's get to some stable, predictable pricing mechanism instead of having every six months or so something that doesn't allow you to figure out what your benefits -- if you can afford the benefits you're offering 18 months ahead of that time, what risk adjustment will really do, at whatever level that is.

Then you're looking forward to perhaps something like a competitive bidding system. This makes it very difficult to make decisions around what you're offering, what your revenue is going to be, and even then -- of course the ultimate customer is the beneficiary, about what they're going to have in place from one year to the next.

So I'm trying to bridge a little bit of a gap here to say that paying in a financially neutral way is a big step forward. I think just recognizing risk adjustment in and of itself needs

to be done carefully and imposed carefully, otherwise as policymakers here we shouldn't be surprised that there's further destabilization if it's not done in a thoughtful and careful way.

I'm looking at more of a minimalist approach right now. We have done the data for the inpatient hospitalization. It's 10 percent. The outpatient and the burden that it was going to impose on fragile provider networks, thus de facto exiting the markets, was also very, very concerning to us in terms of what we were able to be able to commit to to our provider partners in the system.

So again, I started out with where are we with this recommendation, but I appreciate the comments of those that recognize that a bit of caution here is worth the -- able to bridge to whatever we go to next.

DR. NELSON: Glenn, can I clarify, because I think Janet may have misunderstood me, and if she did others may have too. When I was saying that choice was important to beneficiaries, I meant the choice between traditional Medicare and Medicare+Choice and its various plans. I just want to make that clear.

MR. HACKBARTH: David, then Bea, and then we really need to turn to the draft recommendations.

MR. SMITH: I'll try to be very brief. First, I share the concerns that Glenn and Joe raised about the language on lowest bid and maybe we can help work on that.

Let me return to Bob's endangered species analogy. If our task her is to make sure that the circumstance is in some way mitigated then there's no particular reason to stop at 100. We ought to be asking ourselves, how much money do we need to throw into the system in order to prevent further extinction? That's the logical consequence of Bob's proposition, which is that we want to hold on to this apparatus because as the system evolves and as we learn more we don't want to be bereft of these institutions.

I don't think that's what we intend. But if we do, then I think we need to open up the conversation to what's the right number? Is it 105? Is it 110? Is it 100? If the objective here is back to what we've said before, which is appropriate financial neutrality, then it doesn't seem to me we can argue to go to 100 absent appropriate risk adjustment.

But if our objective is holding onto this species which is in difficult shape then there's no particular reason to think 100 is the right answer. I don't know what the right answer is, Bob, but --

DR. REISCHAUER: No, if they can't make it at 100, let them go the way of the dinosaur.

MR. SMITH: Why? You began with, we may have an interest in holding onto this beast because it may be valuable to us later.

DR. REISCHAUER: And we don't know right now what an appropriate risk adjuster would do, because there's been so much turbulence in these plans, in these markets, in the conditions

that face participants, in the sense of premiums and lock-ins. The data suggested to us in the past that we were overpaying plans by 5 or 7 percent may be invalid.

MR. SMITH: I don't disagree with that, Bob. But where you started was not with what we don't know and the appropriateness of modesty. I agree with that. But where you started was, we have an interest in the preservation of the species. If we do, then our recommendation ought to reflect that rather than saying, let's go to 100 absent the kind of risk adjustment which we think is necessary to make 100 work.

DR. REISCHAUER: We have an interest in preservation only to the extent that we think this species might be able to compete on a level playing field, and let's make sure that we don't tilt the playing field against it. That's all. And it would be just a two-year, three-year, whatever it is, adjustment. If we're paying plans now 98 percent, we aren't really talking huge change.

MR. SMITH: I suspect that if we'd find that if we went to 100 and it didn't work, your argument would turn into, let's try 103. It doesn't seem to me that's the path we ought to set off on.

DR. BRAUN: I'd like to preface it by saying I agree with the preface that Alan gave about choice for beneficiaries and so forth. And I agree with Janet that those who are lucky enough to have that choice and have chosen managed care really are delighted with it, and there's a lot of upset when plans exit.

However, with the financial neutrality I'm concerned, as Bob mentioned, that if we do that now it may take some of the steam out of the risk adjustment. Plus the fact that I'm concerned that if indeed the plans do have a healthier population -- and some of the older plans actually may not any more because the people have gotten older and it's costing them much more. But if indeed that is found out and we have already moved to financial neutrality, are they going to be able to back up? What's going to happen indeed, because that might mean that some of them would not be paid as much as they had been before. So that's a concern.

MR. HACKBARTH: What I'd like to do at this point is turn to the draft recommendations. Here's where I think we stand. In terms of the two draft recommendations that the staff offered I think we agreed at the outset that we really don't need number one. That it's superfluous. It's really taken care of by the initial clause in recommendation two.

Bob I think has a proposed alternative to draft recommendation two which I'd like him to go ahead and explain.

DR. REISCHAUER: This is option two for this draft recommendation. It would say, the Congress should set payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending, and an adequate risk adjustment mechanism should be implemented as soon as possible, or feasible. So this

separates the two, because obviously you could go to 100 percent right now.

Now I would assume that what the text around this would talk about was our ignorance with respect to the underlying risk of participants in these plans at present, the desire for a level playing field risk adjusted in the long run, and concern about the withdrawals that have taken place, and the possibility that between now and 2004 this industry may be so weakened that it is no longer viable when the playing field does become level. This is just an alternative.

DR. ROSS: Bob, what does your alternative proposal imply about the use of PIP DCGs as the existing risk adjuster? Allow that to affect payments fully?

DR. REISCHAUER: That's above my pay grade.

DR. ROSS: That's the first question we'll get asked.

DR. REISCHAUER: I'd go to Joe to see whether we should -- you mean phase it in completely as opposed to leave it at --

MR. HACKBARTH: Where are we in the phase-in right now?

DR. REISCHAUER: Ten percent.

DR. NEWHOUSE: The implication seems to be just that we should accelerate the phase-in. That's how I would have read this. When we say an adequate program, I mean I don't -- we talked long ago about what adequate meant. But as Murray says, what's on the table is the PIP DCGs or all sites. We're just basically saying full steam ahead as I would have read this.

DR. STOWERS: I just have a question of Bob. Do you mean at least 100 percent, or those that over 100 percent will decrease down to 100 percent? Will Portland go from 553 to 440?

DR. REISCHAUER: We would go to 100 percent and then do as much risk adjustment as feasible at this point.

MR. HACKBARTH: The answer is, Portland is there because of the floor, and our financial neutrality proposal involves elimination of the floors.

DR. REISCHAUER: Get rid of the floors, right.

DR. STOWERS: So they would go down.

MR. HACKBARTH: They would go down, yes.

DR. STOWERS: So is there a lack of stabilization because of those that are over, which some are on here, are going down, when they have established plans that are in place? We're talking destabilization.

MR. HACKBARTH: Again, we're reopening principles that we agreed to many months ago now, and a clear implication of financial neutrality is that you eliminate the floors.

DR. ROSS: The other question that remains on the table is when we talk about local fee-for-service spending is that defined to include or exclude payments for medical education; the carve-out?

MR. HACKBARTH: So what I would like to do in terms of process is we have the staff's draft recommendation two. Bob has offered an alternative to it. I'd like to vote on Bob's

alternative and then if that doesn't carry then turn to the staff recommendation. Any objection to that process?

MR. MULLER: Bob's alternative in a sense takes the when out, right?

MR. HACKBARTH: Yes, he's saying do it immediately --

MR. FEEZOR: That's without --

MR. HACKBARTH: -- because of the uncertainty.

MS. NEWPORT: I guess I'm not settled on our understanding of what we think Bob's amendment means for risk adjustment. Is it full 100 percent data submission right now, or is it this more compromise proposal that CMS is going forward with?

DR. REISCHAUER: Presumably we have some risk adjustment information that we have chosen not to implement fully, and at the same time CMS is refining that, which I would encourage and think is the right thing to do. Eventually that would supplement what we already have.

MS. NEWPORT: So I just want to make sure our understanding is clear about what that means.

MR. HACKBARTH: Janet, let me see if I understand this correctly. There are two separate issues. One is the phase-in of PIP DCGs. The second is expansion to include non-hospital utilization. What I hear Bob saying is that we ought to move as quickly as possible to do the PIP DCG piece. In terms of the expansion to other sites, the analysis and weighing that is going on in CMS is appropriate but it ought to get done as soon as possible.

DR. REISCHAUER: I changed now, at Lu's suggestion, the word implemented to phased in. And as soon as possible sort of makes it sound like, go to 100 percent next year. We really need some kind of word that suggests at a pace that doesn't disrupt -- I'm trying to save this entity. I then don't want to kill it by having it eat too much medicine in a short period of time.

DR. HARRISON: There is a current phase-in program that's in law, although the thought was that the PIP DCG would be replaced by the multi-site at that point. But do we want to go with a phase-in schedule and leave it up to CMS whether they're going to do PIP DCG or multi-site as it's phased in?

MS. NEWPORT: I think the statute makes the methodology CMS's choice. If we're going to stay with the status quo on this I want it clear, and maybe Bob can reread his --

DR. NEWHOUSE: I think the principal way would be, if anything, to accelerate over where CMS is. But I agree, we don't want to destroy the program to save it.

MS. RAPHAEL: Could you read your recommendation now as it's revised?

DR. REISCHAUER: I don't have the right last word because we need some language about --

MR. HACKBARTH: That could be handled in the text though. There isn't a single right word to capture the idea.

DR. REISCHAUER: Congress should set payments to

Medicare+Choice plans at 100 percent of per capita local fee-for-service spending and an adequate risk adjustment mechanism should be phased in as soon as feasible or possible.

MS. BURKE: I wonder if I could just ask a practical question in terms of the time frame and the impact of this. Is it my understanding the minimums go away? So going to Ray's point -- I'm trying to understand the implications of all that. So to Ray's point, there will be plans that drop. And your expectation, given what you did previously and what you doing today, as to when that will actually occur?

DR. REISCHAUER: I think if we're practical about this, what will happen in the legislative environment is they will freeze the floors and let the sea rise up past them, and it will take 20 years in Lincoln County, Nebraska to get there but...

MS. BURKE: Right. I'm just trying to think of the next actual consideration of this will be in the context of what happens to these plans, and the potential disruption in the short term, particularly for the plans who are at floor who are in these rural areas. I can think of a variety of states for whom that will be an issue, Iowa being among them.

DR. REISCHAUER: But I think the text should say, whenever we refer to moving to a level playing field that this should be done in a way that doesn't cause undue disruption. An awful lot of these places we're talking about imposing a hardship on nobody because there are no plans. So it's sort of like, let's not worry too much about this.

MS. BURKE: Right. I'm just trying to think of the practical realities of how quickly this moves forward.

MR. HACKBARTH: Okay, any further clarifications necessary on Bob's --

MR. MULLER: The basic argument for this is a kind of endangered species argument. Basically, this is something worth keeping until --

DR. REISCHAUER: And our ignorance about --

DR. ROWE: The populations may not be that different so we may not be overpaying.

DR. REISCHAUER: And if we turn down this we go to the old recommendation. So that's the option.

MR. SMITH: But Bob's correct observation that we're very unlikely to lower anybody at the current floor would allow us to rewrite this recommendation to say, if you're above 100 percent, you stay there. If you're not at 100 percent, you go there, and maybe there will be risk adjustment sometime in the future. That's, as a practical matter, what we vote for if we vote for Bob's modification.

DR. HARRISON: Instead of doing the phase-in as quickly as possible, you could just leave the current phase-in schedule so that you know something will happen.

DR. NEWHOUSE: We could say something like, at a minimum, the current phase-in schedule should be maintained, or if

possible, accelerated.

MR. HACKBARTH: Just say that in the text.

DR. REISCHAUER: Phased in at least as rapidly as is called for under current law.

DR. ROSS: The other issue for clarity to add in the text is your assumption about the definition of local fee-for-service spending on the med-ed payments, and whether in text you want us to describe this as embodying, to put it bluntly, column two versus column three in the table that you've seen.

MS. RAPHAEL: Aren't we discussing that next?

MR. HACKBARTH: There is not a specific draft recommendation on the carve-out issue. We discussed at our last meeting a recommendation to say that there should not -- that it should be the total fee-for-service cost, including medical education and that didn't pass. I can't remember the vote but --

MS. NEWPORT: But if you're going to full fee-for-service -- I was separating the issues differently last time in terms of what the base should be. So aren't we confusing the issue, which was reallocation of some of the GME in a way that wasn't beneficial to areas that didn't have a lot of GME?

MR. HACKBARTH: I don't think so. I think we had a quite explicit discussion of whether this is the full fee-for-service cost or fee-for-service minus medical education. We discussed it at length. It was a split vote but there was a clear majority in favor of excluding the medical education payments from the private plans. I think it was unambiguous. Whether it's the right call or not is another question, but I don't think there was any ambiguity.

DR. HARRISON: So did you want that in recommendation language or in text?

MR. HACKBARTH: Text. Are we ready to vote on Bob's proposed amendment? Everybody has got it in their head?

MR. FEEZOR: That is with text on the accelerated -- no less than --

DR. REISCHAUER: At least as rapidly is in the recommendation.

MR. HACKBARTH: Read it one more time.

DR. REISCHAUER: The Congress should set payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending, and an adequate risk adjustment mechanism should be phased in at least as rapidly as called for under current law.

MR. HACKBARTH: All opposed?

All in favor?

Abstain?

It passes. Did you get the count on that? What was the number?

MS. ZAWISTOWICH: Alan Nelson and David Smith voted no, and Mary abstained.

MR. HACKBARTH: Okay, I think we're done then on Medicare+Choice.

DR. ROWE: I think it's interesting to note that we had two votes with respect to these issues. One of the issues could be interpreted as having passed to give the plans less money, and two people voted against it. The other passed having interpreted to give the plans more money with two people voting against it. So it looks like at some level the system might be working here.

[Laughter.]

MR. HACKBARTH: The next item on the agenda is adjusting for local differences in resident training costs.